General

Guideline Title

Occupational therapy practice guidelines for driving and community mobility for older adults.

Bibliographic Source(s)

Stav W. Occupational therapy practice guidelines for driving and community mobility for older adults. Bethesda (MD): American Occupational Therapy Association (AOTA); 2015. 158 p. [320 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Stav WB, Hunt LA, Arbesman M. Occupational therapy practice guidelines for driving and community mobility for older adults. Bethesda (MD): American Occupational Therapy Association (AOTA); 2006. 122 p. [139 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse: In addition to the evidence-based recommendations below, the guideline includes extensive information on the evaluation process and intervention strategies for driving and community mobility for older adults.

Definitions for the strength of recommendations (A–D, I) and levels of evidence (I–V) are provided at the end of the "Major Recommendations" field.

Recommendations for Occupational Therapy Interventions for Driving and Community Mobility for Older Adults

Person

Education

- Combining in-class sessions with individual on-road training can improve driving knowledge and on-road driving performance and significantly reduce unsafe driving actions in specific areas of a road test (A).
- In-class educational sessions alone can improve drivers' knowledge but may not significantly change driving habits (B).
- Imposing driving restrictions on drivers with declining skills yields safety profiles similar to those of "safe" drivers, good compliance with restrictions, and no incidence of reported traffic violations or crashes (C).
- CarFit participants are likely to implement one or more recommendations within 6 months of a CarFit event (C).
- A 2-hr lesson on traffic theory and on-road training can increase traffic theory knowledge and driving performance of people with stroke

(C).
- Education can improve driving self-awareness and driving performance, but may not reduce crashes, in drivers with low vision (C).
- In-class education and on-road training can reduce crashes (I).
- CarFit can improve driving self-regulatory behaviors (I).

Cognitive–perceptual Skills

- Cognitive–perceptual training that typically involves Useful Field of View (UFOV) can lower at-fault crashes, delay driving cessation, and improve driving performance in clients with stroke and right hemisphere lesions (B).
- Video-based hazard perception training can improve the latency of hazard perception ability in older drivers (B).
- Computer-based cognitive speed of processing training can improve response times and performance on a driving simulator (C).
- Use of the Dynavision Light Training Board can improve on-road driving performance of drivers after stroke (I).
- Use of a bioptic telescopic lens or visual field enhancement system (e.g., prisms) can improve driving performance in people with low vision (C).

Physical Fitness

- Physical retraining can improve the driving skills of older drivers (B).
- A 12-week graduated exercise program can maintain driving performance (B).
- A 12-week home- or community-based fitness program combining physical tasks with challenges to cognitive–perceptual skills can improve simulator driving performance (B).
- Physical fitness programs mimicking driving behaviors can improve driving skills and confidence (C).
- Physical fitness training can reduce crash risk (I).

Simulator Training

- A 15-hour program of standardized driver simulation training can improve on-road driving performance in people with stroke (B).
- Active personalized feedback during videotaped simulated driving performance can improve identification of peripheral hazards, receptiveness to changing driving behaviors, and performance of secondary looks during real-world driving (C).

On-road Training

- On-road training combined with a classroom session can increase real-world driving performance (A).
- Coaching during on-road training that focuses on approaching and negotiating hazards can improve driving behaviors and skills (C).
- Personalized feedback on peripheral hazards at intersections can improve secondary looks in community driving (C).
- On-road and classroom training with drivers with stroke can improve driving performance (C).

Community

Licensure Policy

- Licensing restrictions can reduce moving violations, crashes, and fatalities (I).
- Current licensing restriction policies can identify high-risk older drivers (I).
- Vision testing as part of licensing can reduce crashes or fatalities (I).
- Age-based required reevaluation beginning at age 45 can reduce crashes or fatalities (I).

Driving Cessation

Driving cessation group intervention for caregivers of people with dementia can reduce depression, improve self-efficacy and communication, improve acceptance of circumstances and quality of life, and better prepare the driver and caregiver for cessation of driving (B).

Community Mobility

- An education program to inform participants about mobility transition choices can increase their knowledge of community mobility options (C).
- Group transit training can increase bus use by older adults but may not reduce days of automobile driving (C).
- Shop-and-ride programs can increase rides by older adults to participating merchants (C).
- Additional bus service, more reliable equipment, and on-time performance can result in increased customer satisfaction by older adults (C).

Walkable Communities

- Living in walkable neighborhoods can reduce driving and increase walking (C).
- Midrange density and connectivity and a slope of ≤5% may be the most conducive conditions to encourage older adults to walk (C).

Automobile Modifications

High Tech

- Adaptive cruise control can reduce workload and driving stress (B).
- Dynamic or intelligent speed limit systems can improve homogeneity of speed (B).
- Collision avoidance systems can reduce collisions (B).
- Advanced driver assistance systems can assist with driving (I).
- Use of countermeasures such as blind spot detection, lane departure warning, and driver state monitoring can assist with driving (I).
- Use of complex auditory navigation systems may decrease safety (C).

Low Tech

- Electronic stability control can reduce loss of control while driving (B).
- Postural support aids can improve driving performance and reduce exertion during driving (C).
- Hand controls do not present a higher task demand for older adults (C).
- An embedded warning signal (compared with conventional rear brake lights) can improve brake response times (C).
- Hydrophobic treatment of windshields has not been shown to provide benefit (I).
- Antilock brake systems provide no significant protection (C).
- Airbags provide no significant mortality risk but may increase susceptibility to injury in minor collisions (C).
- Aftermarket tinting may negatively affect older adult driving performance (D).

Definitions

Levels of Evidence for Occupational Therapy Outcomes Research

Levels of Evidence	Definition
Level I	Systematic reviews, meta-analyses, and randomized controlled trials (RCTs)
Level II	Two groups, nonrandomized studies (e.g., cohort, case control)
Level III	One group, nonrandomized (e.g., before-after, pretest and posttest)
Level IV	Descriptive studies that include analysis of outcomes (e.g., single-subject design, case series)
Level V	Case reports and expert opinions that include narrative literature reviews and consensus statements

Note: Adapted from "Evidence-based medicine: What it is and what it isn't." D. L. Sackett, W. M. Rosenberg, J. A. Muir Gray, R. B. Haynes, & W. S. Richardson, 1996, *British Medical Journal*, 312, pp. 71-72. Copyright © 1996 by the British Medical Association. Adapted with permission.

Strength of Recommendations

A–There is strong evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. Good evidence was found that the intervention improves important outcomes and that benefits substantially outweigh harm.

B–There is moderate evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.

C–There is weak evidence that the intervention can improve outcomes. It is recommended that the intervention be provided selectively on the basis of professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.

I–There is insufficient evidence to determine whether or not occupational therapy practitioners should be routinely providing the intervention. Evidence that the intervention is effective is lacking, of poor quality, or conflicting and the balance of benefits and harm cannot be determined.

D–It is recommended that occupational therapy practitioners not provide the intervention to eligible clients. At least fair evidence was found that the intervention is ineffective or that harm outweighs benefits.

Note: Criteria for level of evidence and recommendations (A, B, C, I, D) are based on standard language from the U.S. Preventive Services Task Force (2012). Suggested

recommendations are based on the available evidence and content experts' clinical expertise regarding the value of using it.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Any disease or condition affecting ability to drive or mobility within the community

Guideline Category

Counseling

Evaluation

Management

Prevention

Rehabilitation

Risk Assessment

Screening

Clinical Specialty

Family Practice

Geriatrics

Internal Medicine

Neurology

Ophthalmology

Physical Medicine and Rehabilitation

Preventive Medicine

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Health Plans

Hospitals

Managed Care Organizations

Nurses

Occupational Therapists

Optometrists

Physical Therapists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Utilization Management

Guideline Objective(s)

- To provide an overview of the occupational therapy process to address driving and community mobility among older adults
- To define the occupational therapy process and the nature, frequency, and duration of intervention that occurs within the boundaries of acceptable practice
- To help occupational therapists and occupational therapy assistants, as well as people who manage, reimburse, and set policy regarding occupational therapy services, understand the contribution of occupational therapy in treating older adults with driving and community mobility needs
- To serve as a reference for health care practitioners, state driver licensing agencies, age-related agencies, transit and transportation authorities, municipal planning organizations, older adults, families and caregivers, health care facility managers, education and health care regulators, third-party payers, and managed care organizations

Target Population

Older adults with driving and community mobility needs

Interventions and Practices Considered

1. Driver education
    - Combination in-class and on-road training
    - Driving restrictions for drivers with declining skills
    - Participation in CarFit events
    - Traffic theory and on-road training lessons
2. Cognitive perceptual skills training
    - Useful Field of View (UFOV)
    - Video-based hazard perception training
    - Computer-based cognitive speed of processing training
    - Dynavision light training board
    - Bioptic telescopic lens or visual field enhancement system (e.g., prisms)
3. Physical fitness training
4. Simulator training
5. Community interventions

    - Licensure policy (licensing restrictions, vision testing, age-based reevaluation)
    - Driving cessation
    - Community mobility
    - Walkable communities
6. Automobile modifications (high- and low-tech)

Major Outcomes Considered

- Validity and reliability of assessment tools
- Effectiveness of interventions
- Driving skills and performance
- Driving awareness and behavior
- Reaction and response time
- Fatality rates among older adults

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The following four focused questions served as the basis for the systematic reviews of occupational therapy interventions and assessments for driving and community mobility for older adults:

1. What is the evidence supporting the use of clinical assessments (vision, cognition, physical function) and performance-based assessments (simulated and on-road) for determining driving safety and competence and the need for driving cessation of older adults?
2. What is the evidence for the effect of interventions to address cognitive function, visual function, motor function, driving skills, self-regulation and self-awareness, and the role of passengers and family involvement in the driving ability, performance, and safety of older adults?
3. What is the evidence for the effect of automobile-related modifications on driving ability, performance, and safety of older adults? Modifications include changes by the industry that enhance or hinder the driving ability, performance, and safety of older adults.
4. What is the evidence for the effect for policy and community mobility programs (e.g., alternative transportation, walkable communities, education, driving cessation programs, pedestrian programs) on the performance and participation of older adults?

Search terms for the review were developed by the methodology consultant to the American Occupational Therapy Association, Inc. (AOTA) Evidence-Based Practice (EBP) Project and AOTA staff in consultation with the authors of each question and were reviewed by the advisory group. The search terms were developed not only to capture pertinent articles but also to ensure that the terms relevant to the specific thesaurus of each database were included. Table C1 in the original guideline document lists the search terms related to population and intervention included in each systematic review. A medical research librarian with experience in completing systematic review searches conducted all searches and confirmed and improved the search strategies.

Databases and sites searched included Medline, PsycINFO, CINAHL, AgeLine, Ergonomics Abstracts, Transportation Research International Documentation, IEEE Xplore, and OTseeker. In addition, consolidated information sources, such as the Cochrane Database of Systematic Reviews and the Campbell Collaboration, were included in the search; these databases are peer-reviewed summaries of journal articles and provide a system for clinicians and scientists to conduct evidence-based reviews of selected clinical questions and topics. Moreover, reference lists from articles included in the systematic reviews were examined for potential articles, and selected journals were hand searched to ensure that all appropriate articles were included.

Inclusion and exclusion criteria are critical to the systematic review process because they provide the structure for the quality, type, and years of publication of the literature incorporated into a review. The review of all four questions was limited to peer-reviewed scientific literature published in English. The intervention approaches examined were related to older adult driving and were within the scope of practice of occupational therapy. The literature included in the review was published between 2005 and April 2011. The earlier reviews included studies published between 1985 and 2004. The assessment studies examined were published between 1990 and April 2011 and assessed predictive or concurrent validity. The studies also incorporated some assessments commonly used by occupational therapy practitioners. The review excluded data from presentations, conference proceedings, non–peer-reviewed research literature, dissertations, and theses. Studies included in the review provide Level I, II, and III evidence; Level VI and V evidence was included only if higher-level evidence on a given topic was not found.

A total of 5,797 citations and abstracts were included in the reviews. The question on assessment had 1,743 references, person interventions had 1,609, car interventions had 735, and policy and community mobility interventions had 1,710 references. The methodology consultant completed the first step of eliminating references on the basis of the citation and abstract. The systematic reviews were carried out as academic partnerships in which academic faculty worked with graduate students to carry out the reviews. Review teams completed an additional step of eliminating references on the basis of citation and abstract. The full-text versions of potential articles were retrieved, and the review teams determined final inclusion in the review on the basis of predetermined inclusion and exclusion criteria.

Number of Source Documents

A total of 135 articles were included in the final review. The review included 34 Level I studies, 34 Level II studies, 64 Level III studies, and 3 Level IV studies.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence for Occupational Therapy Outcomes Research

Levels of Evidence	Definition
Level I	Systematic reviews, meta-analyses, and randomized controlled trials (RCTs)
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Level IV	Descriptive studies that include analysis of outcomes (e.g., single-subject design, case series)
Level V	Case reports and expert opinions, which include narrative literature reviews and consensus statements

Note: Adapted from "Evidence-based medicine: What it is and what it isn't." D. L. Sackett, W. M. Rosenberg, J. A. Muir Gray, R. B. Haynes, & W. S. Richardson, 1996, *British Medical Journal*, 312, pp. 71-72.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

The teams working on each focused question reviewed the articles according to their quality (scientific rigor and lack of bias) and level of evidence. Each article included in the review was then abstracted using an evidence table that provides a summary of the methods and findings of the article and an appraisal of the strengths and weaknesses of the study based on design and methodology. American Occupational Therapy Association,

Inc. (AOTA) staff and the Evidence-Based Practice (EBP) Project consultant reviewed the evidence tables to ensure quality control.

The limitations of the systematic reviews are based on the design and methods of individual studies and include limited description of a training program, limited follow-up, small sample sizes, high dropout rates, and lack of a control group or randomization. In addition, a variety of assessments and outcomes were used, making it difficult to group the intervention and assessment studies together.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

A major focus of the American Occupational Therapy Association, Inc. (AOTA)'s Evidence-Based Practice (EBP) projects is an ongoing program of systematic review of multidisciplinary scientific literature, using focused questions and standardized procedures to identify practice-relevant evidence and discuss its implications for practice, education, and research. An evidence-based perspective is founded on the assumption that scientific evidence of the effectiveness of occupational therapy intervention can be judged to be more or less strong and valid according to a hierarchy of research designs, an assessment of the quality of the research, or both. AOTA uses standards of evidence modeled on those developed in evidence-based medicine. This model standardizes and ranks the value of scientific evidence for biomedical practice using the grading system presented in the "Rating Scheme for the Strength of the Evidence" field of this summary.

In this system, the highest level of evidence, Level I, includes systematic reviews of the literature, meta-analyses, and randomized controlled trials (RCTs). In RCTs, participants are randomly allocated to either an intervention or a control group, and the outcomes of both groups are compared. Other levels of evidence include Level II studies, in which assignment to a treatment or a control group is not randomized (cohort study); Level III studies, which do not have a control group; and Level IV studies, which use a single-case experimental design, sometimes reported for several participants. Finally, Level V studies are case reports and expert opinion that include narrative literature reviews and consensus statements.

The systematic reviews on driving and community mobility for older adults were supported by AOTA as part of the EBP Project and are based on the need for occupational therapy practitioners to have access to the results of the latest and best available literature to support intervention within the scope of occupational therapy practice. AOTA is committed to supporting the role of occupational therapy in this important area of practice. Previous systematic reviews for the focused questions targeting aspects of intervention were completed covering the time frame of 1985 to 2004. The current systematic reviews on these questions were updated for the period 2005 through April 2011. The new question on assessments covered the period of 1990 through April 2011.

The three focused questions developed for the updated review were on the basis of those of the earlier review. The assessment question was developed on the basis of feedback from the earlier review regarding the importance of including a systematic review on assessment in the updated version of the practice guideline. The four questions were reviewed by review authors, an advisory group of experts in the field, AOTA staff, and the methodology consultant to the AOTA EBP Project.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendations

A–There is strong evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. Good evidence was found that the intervention improves important outcomes and that benefits substantially outweigh harm.

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Note: Criteria for level of evidence and recommendations (A, B, C, I, D) are based on standard language from the U.S. Preventive Services Task Force (2012). Suggested recommendations are based on the available evidence and content experts' clinical expertise regarding the value of using it.

Cost Analysis

The guideline developers reviewed published cost analyses.

Method of Guideline Validation

Peer Review

Description of Method of Guideline Validation

This practice guideline was reviewed by a group of content experts in driving and community mobility that included a consumer representative.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

The final review included 135 articles. Studies included in the review are Level I, II, and III evidence. Level IV and V evidence was included only when higher level evidence on a given topic was not found.

Number of Articles in Each Review at Each Level of Evidence

Review	Evidence Level					Total in Each Review
	I	II	III	IV	V	
Assessment	5	6	53	0	0	64
Intervention: Person	21	5	1	3	0	30
Intervention: Automobile	4	16	5	0	0	25
Intervention: Policy and community mobility	4	7	5	0	0	16
Total	34	34	64	3	0	135

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

These guidelines may be used to assist:

- Occupational therapists and occupational therapy assistants in communicating about their services to external audience
- Other health care practitioners, state driver licensing agencies, age-related agencies, transit and transportation authorities, municipal planning organizations, older adults, families and caregivers, and health care facility managers in determining whether referral for occupational therapy services would be appropriate
- Third-party payers in determining the medical necessity for occupational therapy services
- Health and education planning teams in determining a population's or community's need for occupational therapy services
- Legislators, third-party payers, and administrators in understanding the professional education, training, and skills of occupational therapists and occupational therapy assistants (see Appendix A in the original guideline document)

- Program developers, administrators, legislators, and third-party payers in understanding the scope of occupational therapy services
- Program evaluators and policy analysts in the practice area of driving and community mobility in determining outcome measures for use in analyzing the effectiveness of occupational therapy intervention
- Policy, education, and health care benefit analysts in understanding the appropriateness of occupational therapy services for driving and community mobility for older adults
- Occupational therapy educators in designing appropriate curricula that incorporate the role of occupational therapy related to driving and community mobility among older adults

Potential Harms

- Before implementing any new intervention with a patient, it is always prudent for the occupational therapy practitioner to be aware of the potential benefits and harms of the intervention. Clinical reasoning based on a sound evaluation of the patient's strengths and limitations and an understanding of the intervention should be exercised to determine its potential benefits and harms.
- Simulator sickness is a significant problem, particularly for older adults, and practitioners need to be able to address this side effect
- Although the on-road driving assessment is viewed as the most valuable tool in determining fitness to drive, it may be problematic for reasons including the following:
    - Safety risk and liability are associated with taking a client in a moving vehicle on unpredictable roadways
    - Overlearned skills or the habitual nature of driving a vehicle may give a false impression of competence, allowing an impaired driver to continue driving

Qualifying Statements

Qualifying Statements

- This guideline does not include all appropriate methods of care, and it does not recommend any specific method of care as appropriate; the occupational therapist makes the ultimate judgment regarding the appropriateness of a given procedure in light of a specific client's circumstances and needs.
- This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold or distributed with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional service. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.
- It is the objective of the American Occupational Therapy Association, Inc. (AOTA) to be a forum for free expression and interchange of ideas. The opinions expressed by the contributors to this work are their own and not necessarily those of the AOTA.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Patient Resources

Resources

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Safety

Identifying Information and Availability

Bibliographic Source(s)

Stav W. Occupational therapy practice guidelines for driving and community mobility for older adults. Bethesda (MD): American Occupational Therapy Association (AOTA); 2015. 158 p. [320 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2006 (revised 2015)

Guideline Developer(s)

American Occupational Therapy Association, Inc. - Professional Association

Source(s) of Funding

American Occupational Therapy Association, Inc.

Guideline Committee

Not stated

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Financial Disclosures/Conflicts of Interest

The authors of this practice guideline have signed a conflict-of-interest statement indicating that they have no conflicts that would bear on this work.

Guideline Status

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This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Electronic copies: Not available at this time.

Print copies: Available for purchase from The American Occupational Therapy Association (AOTA), Inc., 4720 Montgomery Lane, Bethesda, MD 20814, Phone: 1-877-404-AOTA (2682), TDD: 800-377-8555, Fax: 301-652-7711. This guideline can also be ordered online from the AOTA Web site.

Availability of Companion Documents

The following are available:

- Occupational therapy practice framework: domain and process. 3rd ed. Bethesda (MD): American Occupational Therapy Association, Inc. (AOTA); 2014. Available to order from the American Occupational Therapy Association, Inc. (AOTA) Web site .
- Driving and transportation alternatives for older adults. Fact sheet. Bethesda (MD): American Occupational Therapy Association, Inc. (AOTA); 2012. 2 p. Available from the AOTA Web site.

In addition, case studies are available in the original guideline document.

Patient Resources

The following is available:

- Driving safely as you age. Tip sheet. Bethesda (MD): American Occupational Therapy Association, Inc. (AOTA); 2012. 2 p. Available from the American Occupational Therapy Association (AOTA) Web site.

NGC Status

This NGC summary was completed by ECRI Institute on October 28, 2010. This summary was updated by ECRI Institute on October 23, 2015.

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